Response

We thank Dr Phillips for his letter[1] in response to our article[2] in the July issue of *Canadian Family Physician* that recognized the College of Family Physicians of Canada (CFPC), along with many other family medicine organizations and groups, is leading the way in transparency and reduction of bias within clinical practice guidelines (CPGs).[2]

We also thank Dr Lexchin for his letter[3] stressing the important and concerning influence of financial support on CPGs. In drafting these CPG endorsement criteria, this factor was a principal consideration in our deliberation and discussion.

We would like to draw a distinction between guidelines produced by the CFPC and those that the CFPC reviews from other organizations. Clinical practice guidelines produced by the CFPC in collaboration with PEER (Patients, Experience, Evidence, Research) have the highest standards, including the exclusion of anyone with a financial conflict of interest from participating on guideline committees or on the evidence team. No funding from pharmaceutical or medical device industries, directly or indirectly, is accepted for any guideline development itself.

For endorsement of guidelines submitted from outside the CFPC, we recognize that many institutions struggle to completely exclude funding or financial conflicts with industry. The CFPC Guideline and Knowledge Translation Expert Working Group, which approved these criteria, also believed that the presence of a conflict of interest does not mean de facto that bias occurs. The working group did not want to exclude guidelines from consideration without broader assessment of the degree of conflict, the processes used to manage conflict, and the guideline overall.

The appendix to our article[2] provides the actual endorsement criteria, how they are applied, and a guide of what we look for. While not absolute exclusions, issues like pharmaceutical industry sponsorship of the guideline will strongly tip the balance away from endorsement. Sponsorship includes the indirect methods of financial support mentioned by Dr Lexchin, an element that we did consider and included in the CFPC endorsement criteria for both the applicant and the reviewers.

As to guideline panels with potential financial conflicts, recent Canadian guidance[4] does not prohibit the inclusion of participants with conflicts. Our criteria allow for careful dissection of conflicts (if acknowledged), including the proportion of participants with potential conflicts, whether the chair had potential conflicts, and how these conflicts were managed. Like Dr Lexchin, we were deeply concerned about any participation of industry employees on guideline panels, so we wanted to make sure that that was specifically identified in our criteria and described. While we did not state that any of these criteria would automatically result in a rejection of endorsement, these factors potentially weigh heavily against endorsement and need to be understood for adequate assessment. To critically evaluate the guideline, these factors must be identified, clear, and transparent. That is why we have included them in our criteria. Without specific mention in our criteria, they could be missed.

While financial conflicts and sponsorship are important, there are many potential biases and limitations that impact practical use and application in primary care. The Guideline and Knowledge Translation Expert Working Group placed high value on several aspects in the guidelines: adequate representation of family physicians and other health professionals, practical application in comprehensive care, involvement of patients and focus on shared decision making, appropriate evidence assessment, and more.

As mentioned from the start, the CFPC criteria and family medicine in general continue to set the standards in expectations of CPG quality and transparency.

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Competing interests
None declared

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Environmental effect of smoking cessation

We thank the authors for their useful review of bupropion for smoking cessation in adolescents, published in the climate change–themed October issue of *Canadian Family Physician*.[1] We would like to highlight that smoking cessation, in addition to being good for patient care, is a climate change intervention. Helping a patient quit smoking prevents tobacco-related illness and reduces the carbon

footprint of both cigarette production and the health care burden of tobacco-related illness.

Producing just 1 cigarette takes 3.7 L of water and 3.5 g of oil, making cigarette production responsible for 0.2% of global carbon emissions.[2] Additionally, tobacco and cigarette production reduces the capability of agricultural land to produce food for consumption, increasing food insecurity in vulnerable populations and contributing to deforestation.[2,3]

Every health care activity has an environmental impact. Every procedure, test, and treatment consumes energy and resources, and produces waste.[4] By enabling our adolescent patients to stop smoking, we can substantially improve their health, and also reduce the carbon emissions that would have been associated with tobacco production and tobacco-related illness.

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We acknowledge **Tatiana Gayowsky**, HBASc, Project Coordinator for the Hamilton Family Health Team Green Initiative, for her research data on cigarettes.

Competing interests
Nore declared

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Focusing on breadth of competence

Dr Sandell[1] has some interesting arguments in the September issue of *Canadian Family Physician* as to why we should call ourselves GPs. Is the term *family physician* inaccurate? Perhaps. As a recent Canadian family medicine graduate, I currently work in a beautiful rural community hospital—the only hospital in a 150-km radius of dense forest with a single access road. We serve a diverse population of locals, including Indigenous people who compose the backbone of our community, and numerous visitors and tourists. Here, physicians trained in family medicine truly are GPs.

With the vital support of our nurses, allied health care professionals, and few specialist colleagues, GPs allow our hospital to function. In fact, despite being undervalued and often criticized for systemic shortcomings, they allow our entire health care system to operate smoothly. Their versatility, breadth of knowledge, and skills enable them to treat both acute and chronic conditions in patients of all ages, from the first day of life to the very last. Witnessing the excellent work my GP colleagues accomplish, whether in the family medicine clinic, emergency department, hospital ward, delivery room, palliative care unit, short stay geriatric unit, or in home visits and long-term care homes makes me proud to be part of this group. In the end, physicians trained in family medicine are the most versatile physicians out there. And whether we decide to call ourselves family physicians, GPs, or even primary care physicians, we are all truly making a difference.

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Competing interests
Nore declared

Reference
1. Sandell A. I'm a GP. *Can Fam Physician* 2021;67:691-2.

Can Fam Physician 2021;67:883. DOI: 10.46747/cfp.6712883

Correction

In the article "Primary care clinicians' knowledge, attitudes, and practices concerning dementia. They are willing and need support,"[1] which appeared in the October issue of *Canadian Family Physician,* an author was omitted. The correct byline and affiliations are below:

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The online version of the article has been corrected.

Reference
1. Arsenault-Lapierre G, Henein M, Rojas-Rozo L, Bergman H, Couturier Y, Vedel I. Primary care clinicians' knowledge, attitudes, and practices concerning dementia. They are willing and need support. *Can Fam Physician* 2021;67:731-5 (Eng), e275-9 (Fr).

Can Fam Physician 2021;67:883. DOI: 10.46747/cfp.6712883_1

Correction

Dans l'article intitulé « Les connaissances, les attitudes et les pratiques des cliniciens de soins primaires. Ils sont réceptifs et ont besoin de soutien »[1] et publié dans le numéro d'octobre du *Médecin de famille canadien,* une auteure a été omise de la liste des signataires. La légende et les affiliations devaient se lire comme suit :

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